Municipal Health Benefit Fund

P.O. Box 188
North Little Rock, AR 72115
(501) 374-3484

THIS FORM MUST BE COMPLETED BY MEMBER/EMPLOYEE

NAME OF CITY OR ENTITY _____

MEMBER'S NAME _____

DATE OF BIRTH _____ SEX _____

STREET ADDRESS _____

CITY & STATE _____
ZIP CODE

Eligible Class (Please check applicable class)

- ☐ **Elected Official** _____ (Office)
- ☐ **Member of** _____ **Board or Commission**
- ☐ **Volunteer Firefighter**
- ☐ **Auxiliary Policeman**
- ☐ **Retired Status**
- ☐ **Full Time Active Employee (Working at least 30 hours per week)**

I HEREBY PRESENT THIS CLAIM, and authorize any individual or organization to release information required for its acceptance.

1 CLAIM IS BEING MADE FOR:

☐ Self ☐ Unmarried child to age 19

☐ Wife/Husband ☐ Unmarried full time student age 19 and over, attending _____

2 PATIENT'S NAME | DATE OF BIRTH | SEX

3 IS CLAIM DUE TO AN ACCIDENT? ☐ Yes ☐ No | IF 'YES', WHERE DID ACCIDENT OCCUR? | DATE OF ACCIDENT

DESCRIBE ACCIDENT:

4 IS THIS CLAIM THE RESULT OF A WORK RELATED ILLNESS OR INJURY? ☐ Yes ☐ No **IF YES, PLEASE FILE WITH WORKERS' COMPENSATION CARRIER FIRST.**

5 IF MARRIED, IS YOUR WIFE/HUSBAND EMPLOYED? ☐ Yes ☐ No

NAME

EMPLOYER

ADDRESS

5a IF CLAIM IS FOR A DEPENDENT CHILD, IS THIS CHILD EMPLOYED? ☐ Yes ☐ No

EMPLOYER

ADDRESS

6 IS PATIENT ALSO COVERED FOR ANY **OTHER** INSURANCE BENEFITS AS LISTED BELOW, EITHER AS AN EMPLOYEE OR DEPENDENT? ☐ Yes ☐ No

If Yes, check box below which applies and complete 6a.

- ☐ Group health insurance of any kind including Blue Cross and Blue Shield
- ☐ Coverage of medical care expenses provided by an employer, a union welfare plan, any federal, state, provincial or other governmental program.
- ☐ Other arrangement of benefits for individuals of a group

6a GIVE NAME AND ADDRESS OF **OTHER** COMPANY OR ORGANIZATION PROVIDING INSURANCE:

NAME

ADDRESS

OTHER INSURANCE OR BLUE CROSS/BLUE SHIELD GROUP NO.(s)

8 MEMBER/EMPLOYEE'S SIGNATURE | SOC. SEC. NO. / / | DATE

EMPLOYER'S STATEMENT

EFFECTIVE DATE OF COVERAGE

MEMBER/EMPLOYEE

DEPT.

DATE

IS PATIENT'S COVERAGE CURRENTLY IN FORCE?
YES NO DATE TERMINATED

CITY OF

SIGNATURE OF EMPLOYER'S REPRESENTATIVE

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

MUNICIPAL HEALTH BENEFIT CLAIM FORM

CARRIER

PICA ☐☐☐ PICA ☐☐☐

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. MEMBER'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. MEMBER'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO MEMBER Self ☐ Spouse ☐ Child ☐ Other ☐

7. MEMBER'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. MEMBER'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. MEMBER'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. HEALTH PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. MEMBER'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

HICF-2-W/C

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (6/93)